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IN THE

Supreme Court of the United States

October Term, 1975
No. 75-1333

PARAMOUNT CONVALESCENT CENTER, INC.,
Petitioner,

vs.

DEPARTMENT OF HEALTH CARE SERVICES, *et al.*,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF CALIFORNIA

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Dated: May 3, 1976.

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Opinion Below

The opinion of the Supreme Court of the State of California is reported at 15 Cal. 3d 489 and appears in petitioner's brief as Appendix A.

Jurisdiction

The jurisdictional requisites are adequately set forth in the petition.

Question Presented

Where as a result of several health inspections a skilled nursing facility has demonstrated a continual inability to comply with applicable regulations, and, as a result thereof, the State Department of Health has refused to enter into a new agreement with the facility entitling the latter to participate in the Medi-

Cal Program, must the state afford the facility a hearing before its decision may be effective?

Provisions of Law Involved

The provisions of law involved are set forth in Appendix A hereto in the order in which they appear in the text.

Statement of the Case

Facts

Throughout the period under discussion, petitioner was the owner of a skilled nursing facility licensed by the California State Department of Health.[1] Certain of the patients cared for at petitioner's facility were eligible beneficiaries of the state's Medicaid program.[2] In order for the facility to participate in said program as a provider of medical services and thus to receive payment therefor, federal[3] and state[4] regulations require that there be executed and be in effect a provider participation agreement between the facility and the responsible single State Agency.[5]

Petitioner had been a certified Medi-Cal provider since 1968. The first participation agreement of relevance was executed on June 14, 1972 and was stipulated to expire on July 31, 1972. On July 20-21, 1972 the respondent conducted an inspection of petitioner's facility and found twenty deficiencies. A letter

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[1]California Health and Safety Code section 1250 *et seq.*

[2]In California said program is denominated "Medi-Cal," see Welfare and Institutions Code section 14000 *et seq.*

[3]45 C.F.R. § 250.21.

[4]Title 22 California Administrative Code § 51215.

[5]Formerly the Department of Health Care Services, now the State Department of Health, which is referred to herein as respondent.

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explaining the deficiencies was sent to petitioner on July 27, 1972, which included a request that petitioner prepare and forward a plan for correction of these deficiencies. The acts complained of included incomplete and incorrect nursing notes and patient chart entries, failure to give patients medication as ordered by physicians, water temperature at tub and other patients' fixtures at a dangerous high of 160 degrees Fahrenheit, failure to provide patients with clean towels, and inadequate nursing care.

On August 10, 1972 respondent by letter again requested that petitioner submit a plan of correction as to the July inspection. In the interim, a new participation agreement had been executed extending coverage through October 31, 1972.

A second inspection of petitioner's facility was performed on September 20-21, 1972 wherein forty-one deficiencies were revealed. The deficiencies found during this inspection were set forth in a letter to petitioner from the respondent on October 12, 1972. The violations included incomplete and inadequate nursing notes and patient chart entries, inadequate nursing staff, lack of a supervising registered nurse, the assignment of a nurse's aide to sterilize patients' bedside equipment who did not know how to operate the sterilizer, and improper patient care. A plan of correction was again requested, and petitioner prepared and forwarded one on October 23, 1972.

This response was considered unsatisfactory and, consequently, respondent in a letter dated November 15, 1972, informed petitioner that due to the number and continuing nature of deficiencies at the facility a new participation agreement would not be executed. In order

to assure an orderly transfer of Medi-Cal patients from the facility, however, thirty-day and twenty-one-day extensions to the agreement were granted. The last date upon which any contract between the parties was in effect was December 21, 1972.

When informed of respondent's intended action petitioner insisted that it was in full compliance with Medi-Cal regulations. Petitioner then conducted a third inspection on November 22, 1972. On this visit there were still twenty deficiencies noted, among them: Incorrect charting of patient records, failure to follow physicians' orders, nonfunctioning sterilizing equipment, patients being maintained under unsanitary conditions, incontinent patients not receiving proper care, and a general failure to meet minimum standards of care.

Respondent notified petitioner the next day of its findings and a meeting was held that same day to discuss these latest deficiencies. This conference was unproductive and thereafter respondent refused to enter into a new provider participation agreement with petitioner once the last agreement had run its course.

Proceedings Below

In December 1972 petitioner brought a mandamus action in Los Angeles Superior Court. That court issued its writ directing the respondent to provide petitioner an administrative hearing on the issues before taking any action on its decision not to enter into a new participation agreement with the facility. That ruling was upheld by a divided panel of the California Court of Appeal.

The Supreme Court of California in a 6-1 decision reversed the lower court judgment holding, *inter alia,*

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that petitioner had no legal entitlement to a hearing prior to respondent taking action on its decision not to enter into a new provider participation agreement; that the thrust of federal and state law is to assure that Medi-Cal beneficiaries receive care in those skilled nursing facilities which have demonstrated an ability to meet applicable standards and that if any entitlement is created under the law, it is the Medi-Cal recipients who are the beneficiaries thereof and not the skilled nursing facilities; that to require respondent to grant provider hearings prior to its refusal to enter into new agreements would place the respondent in jeopardy of violating its own regulations and those of the federal government, which require that participation agreements be limited to a period of one year, and thus run the risk of losing millions of dollars in federal grants; that, at most, petitioner merely had a hope or unilateral expectancy in having a new participation agreement executed by respondent.

ARGUMENT

Opening Statement

At the outset it must be emphasized that this case does *not* involve a situation wherein the state without affording a prior hearing has suspended or revoked a license, or has rescinded or otherwise terminated an executory contract. Very simply stated, what *is* involved here is a decision by the state, based upon a history of continuing noncompliances with applicable regulations, to refuse to continue to pay Medi-Cal funds to a deficient facility. That decision was effectuated by the respondent's refusal to enter into a new Medi-Cal participation agreement with petitioner once the last agreement between the parties had expired by its own terms.

Petitioner asserts that it is entitled to an evidentiary hearing prior to the state's decision taking effect. Respondent urges, as was held by the Supreme Court of California, that not only is petitioner not entitled to such a hearing but that to grant such a hearing would place respondent in violation of its own and federal law.

This due process issue is unique to the Medicaid program and, as such, presents an extremely narrow range of application. Furthermore, respondent's action was consistent with previous decisions of this Court on the issue of when preliminary due process hearings may be required. Consequently, respondent submits that review by this Court does not appear warranted.

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A. The Opinion Below Does Not Conflict With Prior Decisions of This Court

In an effort to persuade this Court to grant review in this case, petitioner asserts that the opinion below conflicts with prior decisions of this Court concerning the Fourteenth Amendment's protection of liberty and property. In particular, petitioner alleges that there has been a secession from the teachings of *Board of Regents v. Roth*, 408 U.S. 564 (1972).

An examination of the principles enunciated in that case demonstrates that petitioner herein presents no different a situation than that which was before the Court in *Roth, supra.*

The initial inquiry to be made in any case in which the petitioner claims an entitlement to a due process hearing is an appraisal of the nature of the interest at stake. (408 U.S. at p. 571.) Once that interest has been identified it must next be evaluated in order to determine whether it comes within the elevated and constitutionally protected genre of "property" interests. The Court in *Roth, supra,* characterized "property" interests as follows:

> "To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it." (408 U.S. at p. 577.)

Petitioner in this action claims it possesses such an entitlement. The legitimacy of that claim must spring from and be tested against its purported origin:

> "Property interests . . . are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits. . . ." (408 U.S. at p. 577.)

Petitioner's claim of entitlement, therefore, must arise from the agreements between the parties and applicable federal and state laws and regulations. The Medi-Cal provider participation agreements between the parties merely set forth the respective duties thereunder of the parties and are silent with respect to whether or under what conditions future agreements will be executed. Consequently, the examination of legitimacy must be directed to the governing regulations in order to measure and define the expectation of petitioner with respect to the execution of future participation agreements.

Pursuant to agreement and statute the administration of the Medi-Cal program has been preempted by the federal government. 42 U.S.C. § 1396; Welf. & Inst. Code §§ 14003, 14020, 14100.1; 22 Cal. Admin. Code § 50009; *King* v. *Smith*, 392 U.S. 309 (1968); *County of Alameda v. Carleson*, 5 Cal. 3d 730 (1971). Accordingly the program must be administered in strict accordance with federal statutes and regulations.

Federal regulations provide that federal funding of the Medi-Cal program is available *only* where there is an agreement between the state agency and the provider. 45 Code of Federal Regulations section 250.21 provides:

> "A State plan for medical assistance under Title XIX of the Social Security Act must provide

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> for agreements with every person or institution providing services under the State plan. . . ."

State Medi-Cal regulations also contained this requirement. Title 22 Cal. Admin. Code § 51215(a)(12).[6]

Federal regulations further provide that the term of any such agreement shall not exceed the period of one year. 45 C.F.R. § 249.33(a)(6). (*Accord*, Title 22 Cal. Admin. Code, former § 51215(a)(12).)

Federal and state regulations also require that no initial provider agreement or new agreement upon expiration of a prior agreement may be executed unless the state agency determines that the facility is in compliance with each condition of participation in the Medi-Cal program.[7] Those same regulations do provide for the extension of an agreement for up to 60 days but only where it is determined that the health and safety of the patients will not be jeopardized thereby and that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services, or that it is impracticable within such provider agreement period to determine whether such facility is complying with the provisions and requirements under the program. 45 C.F.R. § 249.33(a)(6).

These were the governing regulations which were in effect when petitioner executed the participation agreements in 1972 and during the period when the aforementioned inspections were being conducted and

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[6]§ 51215 has since been amended and the provided participation agreement requirement now appears at subsection (a)(3) thereof. The text of § 51215(a)(12) as it read during the period of time relevant to this action appears in App. A hereto.

[7]45 C.F.R. § 249.33(a)(4)(i); Title 22 Cal. Admin. Code, former § 51215(a)(12).

petitioner was being warned that it was not in compliance and that it was in danger of losing its Medi-Cal provider status.

It is clear from these regulations that a provider could not possibly anticipate automatic renewals of participation agreements since there was a continuing duty on the part of the provider to demonstrate compliance and a continuing mandate to the respondent that it could not execute an agreement until it had satisfied itself as to the facility's compliance. Moreover, if the state agency should violate this mandate, it subjects itself to the loss of federal funds for the Medi-Cal program. 45 C.F.R. § 249.10(b)(4)(i)(c).

Petitioner, however, argues that respondent had historically entered into new agreements upon the expiration of previous contracts and that this practice created a *de facto* policy whereby petitioner held a protectible expectancy. (*See, Perry v. Sindermann,* 408 U.S. 593 (1972).) First of all, there is nothing in the record pertaining to what had been the policy and practice of respondent with respect to what it would do upon the expiration of a participation agreement.

Secondly, petitioner at bar, unlike the respondent in *Perry, supra,* has made no showing of any "common law" resulting from Medi-Cal policies or practices which would raise petitioner's interest from that of a hope to the equivalent of a "property" interest. The teacher in *Perry, supra,* on the other hand, was able to demonstrate through testimony and demonstrative evidence (such as a provision in the Faculty Guide) that there in fact had been reasonable reliance upon expressions by the employing school that, in effect, a teacher would continue to be hired unless dismissed for cause.

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Whereas the commitment of the school in *Perry* was in the nature of a condition subsequent, *i.e.*, that a teacher would remain employed *until* cause for dismissal arose, the situation at bar involves a condition precedent. In other words, a new agreement will not be executed until the provider *first* satisfies all of the conditions of participation.

Thirdly, even had there been a state practice of automatic contract renewal, such a policy could not obviate the requirements and mandate of the regulations cited above. Otherwise, a situation would be presented whereby a provider, notwithstanding his knowledge of regulations to the contrary, could claim a "property" interest which arose from violations of federal and state law.

From the above there can be little question that the petitioner's status is no different than that of the college professor in *Board of Regents v. Roth, supra,* at 578:

> "Thus, the terms of the respondent's appointment secured absolutely no interest in re-employment for the next year. They supported absolutely no possible claim of entitlement to re-employment. Nor, significantly, was there any state statute or University rule or policy that secured his interest in re-employment or that created any legitimate claim to it. In these circumstances, the respondent surely had an abstract concern in being rehired, but he did not have a *property* interest sufficient to require the University authorities to give him a hearing when they declined to renew his contract of employment."

Petitioner takes issue with the California Supreme Court's adherence to the *Roth* rationale and its dif-

ferentiation of the *Perry* decision because, petitioner alleges (Petition p. 16), the court overlooked the fact that the regulation (22 Cal. Admin. Code § 51215), which requires respondent to assure compliance before executing an agreement with the facility was not promulgated until 1972; the inference being that respondent, therefore, may have practiced a policy of entering into new agreements *without* requiring such a showing. It would appear, however, that petitioner is the one who suffers from myopia since *federal* regulations have required the responsible state agency to make such a determination of compliance since at least 1970. (*See*, the text of former 45 C.F.R. § 249.33(a)(2)(i) as set forth in 35 Fed. Reg. 6792 (1970).)

Petitioner also complains that the opinion below adds a new element to the *Roth* decision in that the court held that a petitioner must be the chief beneficiary of the statute under attack in order to claim due process rights thereunder. This characterization of the court's holding is erroneous. The court's discussion on this subject arose only in the context of its response to the contention that the decisions in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and *Perry v. Sindermann, supra, compelled* a holding that petitioner at bar is entitled to a due process hearing.

For this reason, the opinion below is not in conflict with the *Roth* case.[8] In fact, the California Supreme

[8]Petitioner also asserts that the same alleged conflict exists with respect to *Ross v. State of Wisconsin Dept. of Health & Social Serv.*, 369 F. Supp. 570 (E.D. Wisc. 1973). Respondent is unaware of any rule which holds that a conflict between a state supreme court decision and that of a federal district court is a sufficient basis for granting certiorari by this Court. Furthermore, the *Ross* case is distinguishable from the case at bar on several fronts, not the least of which is the fact that there is no indication that *Ross* involved a Medicaid program.

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Court succinctly stated the basis for its decision:

> "We conclude that Paramount's interest in the renewal of the provider contract amounted only to a hope or a unilateral expectation of renewal rather than to legal entitlement." (Petition, App. at A-11.)

The Supreme Court of California also recognized that if respondent were required to accord a hearing prior to its refusal to enter into a new agreement, it would be impossible in most instances to simultaneously abide by the one-year requirement of 45 Code of Federal Regulations section 249.33(a)(6) and 22 California Administrative Code section 51215. Petitioner attempts to ameliorate this both legitimate and practical consideration by suggesting (Petition pp. 11-12), that the court overlooked the possibility of a 60-day extension of the agreement pursuant to 45 Code of Federal Regulations section 249.33(a)(6), thus affording respondent additional time within which to conduct such a hearing.

Such a suggestion, however, completely ignores the condition precedent to such an extension, *i.e.*, "that the health and safety of the patients will not be jeopardized thereby." A mere cursory review of the deficiencies found at petitioner's facility during the three inspections between September and November 1972 clearly demonstrates that the health and safety of the patients therein were in imminent and continuing danger. Furthermore, 22 California Administrative Code section 51452 provides:

> "Violation of any rule or regulation relating to the provision of health care services under the California Medical Assistance Program . . .

shall be deemed contrary to public health, safety, welfare, and morals. . . ."

It is clear, therefore, that petitioner's interest in having a new provider participation agreement executed was not in the nature of a "property" interest and that the opinion below is entirely consistent, rather than in conflict, with previous decisions of this Court.

B. The California Supreme Court Has Not Decided an Important Question of Law Which Has Not Been Settled by This Court

Petitioner's second major argument as to why this Court should grant certiorari is based upon the premise that the California Supreme Court, in holding that a Medi-Cal provider is not entitled to a hearing prior to being terminated from the program, has decided an important question of federal law which has not been settled by this Court. Respondent offers that the discussion above resolves this purported ground for review.

In the first place, petitioner was never "terminated" from the Medi-Cal program. The respondent merely refused to contract with petitioner for the use of its services as a provider of medical treatment and care to Medi-Cal recipients.

Secondly, respondent submits that since the case at bar presents issues so closely analogous to those treated in the *Board of Regents v. Roth* case, *supra,* and since the holding below is wholly consistent with that decision, the important question of law, if there be one, by virtue of the *Roth* decision has *already* been decided by this Court.

Petitioner attempts to avert the *stare decisis* effect of the *Roth* case by alleging that the present case

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comes within the exception mentioned in *Roth* to the effect that a due process hearing may be required "where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him." (408 U.S. at p. 573.)

Respondent will defer to the California Supreme Court's treatment of this argument:

> ". . . [W]e cannot agree that a determination by the department that a nursing facility has failed to meet its burden of showing that it complies with government regulations is the equivalent of a charge of incompetence or immorality. Even if that were true, however, there is a clear distinction between the circumstances of *Roth* and *Zumwalt* and the present case. A major reason why a teacher charged with misconduct or incompetence is entitled to a hearing to enable him to refute the charges against him is to avoid the possibility of damaging his prospects of employment at other schools. In the instant situation, the thrust of the hearing sought by a nursing home is not to enable the facility to clear its name so that it may attract patients outside the Medi-Cal program, but to participate in the program itself." (Petition, App. at A-12, 13.)

The court did not discuss alternatives available to petitioner, such as reapplying for Medi-Cal certification upon correction of the deficiencies, or conversion of the facility to another type of health facility.

Also, those cases[9] in which this Court has mandated a due process hearing involve situations which, when

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[9]*Goss v. Lopez*, 419 U.S. 565 (1975) [suspension of students from school for misconduct]; *Wisconsin v. Constantineau*, 400 U.S. 433 (1971) [publishing notices in liquor stores that respondent was not to be sold alcoholic beverages].

contrasted with a refusal to contract, are polar in terms of the nature of the action taken against the individual and its obvious stigmatic effect upon the claimant's reputation and future.

It should also be noted that in each of those cases, and in *Perry v. Sindermann, supra,* there were no procedural safeguards whereby the aggrieved party might have an opportunity to refute the charges against him and thereby clear his name before the proposed action took place.[10] Here, however, petitioner was given three inspections and the opportunity to submit plans of correction and, in addition, the chance to present its case at an informal office conference. Furthermore, an aggrieved facility can always obtain judicial review of the respondent's decision by seeking a writ of mandate as suggested by the court below. (Petition, App. at A-12.)

Petitioner begs the issue when it asserts that although respondent is empowered (let alone mandated) to refuse to enter into a new participation agreement with a facility where deficiencies exist, such a determination could not be made *accurately* without the aid of a hearing. (Petition p. 25.) This assumes that the facility has already established a "property" interest to which the right to a hearing attaches. As discussed *supra,* no such showing has been made here. Moreover, concerns identical to petitioner's regarding the possibility of error or arbitrariness in the decision-making process by governmental personnel, such as health inspectors and their supervisors here, and thus the need for an evidentiary hearing, were discussed and mitigated

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[10]*Contrast, Arnett v. Kennedy,* 416 U.S. 134 (1974).

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in this Court's very recent decision in *Mathews v. Eldridge*, ... U.S. ....., 96 S.Ct. 893 (1976), wherein it was held:

> "The judicial model of an evidentiary hearing is neither a required, nor even the most effective, method of decisionmaking in all circumstances. The essence of due process is the requirement that 'a person in jeopardy of serious loss [be given] notice of the case against him and opportunity to meet it.' (Citation omitted) . . . In assessing what process is due in this case, *substantial weight must be given to the good-faith judgments of the individuals charged by Congress with the administration of the social welfare system* that the procedures they have provided assure fair consideration of the entitlement claim of individuals." (Emphasis added.) 96 S.Ct. at 909.

In fact, were it postulated that petitioner did have a "property" interest to which attached due process requirements, respondent submits that the procedures which it employed would, under the rationale of the *Eldridge* decision, be held to be adequate. While respondent recognizes that the claimant in the *Eldridge* case was always assured of a post-termination hearing, the majority opinion nevertheless focuses on the quality and adequacy of the government's procedures *prior* to such a hearing to determine whether those procedures comport with due process.

When one compares the procedures employed by the government in the *Eldridge* case and those conducted by the respondent in the case at bar, the similarity and quality are striking. In the following summary of the procedures noted in *Eldridge* respondent has included in brackets the correlative procedure avail-

able under the Medi-Cal program, in general, and which were employed in the instant case, in particular:

(a) investigations were conducted by a team consisting of a physician and a nonmedical person, [inspections conducted by a registered health sanitarian and public health nurse, often accompanied by a social worker and pharmacist];

(b) claimant is informed of the results of the investigation and the evidence upon which a decision to terminate benefits is based, [facility is provided with a copy of the inspection report, setting forth the exact state or federal regulations or laws violated];

(c) claimant is afforded the opportunity to submit other evidence in writing, [facility is required to submit a plan of correction];

(d) claimant is invited to seek assistance from local social security administration office, [facility may request that respondent provide consulting services to assist in the identification or correction of deficiencies];[11]

(e) claimant still has access to income from other sources, [facility is free to accept private patients];

(f) claimant may seek reconsideration of termination decision, [facility may reapply for certification as a Medi-Cal provider].

Furthermore, when one balances the private interest against the public interest at stake in the instant case,

[11]California Health and Safety Code § 1280.

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as was similarly done in *Eldridge, supra,* the scales tip overwhelmingly in favor of the latter. As was stated by the court below:

> "The Medi-Cal program was created for the benefit of those eligible to receive assistance under it, and not for the economic advantage of nursing homes which render services to the beneficiaries. This basic premise imposes upon us the duty to interpret the rules applicable to the program in a manner favorable to the beneficiaries . . . a vulnerable and exploited class of persons who are frequently powerless to vindicate their own rights." (Petition App. at A-14, 15.)

Conclusion

For the foregoing reasons it is respectfully submitted that the petition for writ of certiorari be denied.

Respectfully submitted,

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APPENDIX A.

Provisions of Law Involved.

45 C.F.R. § 250.21.

"A State plan for medical assistance under Title XIX[12] of the Social Security Act must provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees. . . ."

22 California Administrative Code § 51215.

"(a) A skilled nursing facility shall be licensed by the Department, or be exempt under State law from licensure; and meet all of the standards set forth herein or be certified as a participating provider of extended care facility services under Title XVIII of the Social Security Act and meet the standards set forth in paragraphs (1), (2), (10), (11) and (12) of this subsection.

". . .

"(12) Enter into a participation agreement with the Department that the facility is in compliance with the provisions of this section. The participation agreement with the Department shall remain in effect no longer than the period of certification established under (a) (12) (B) of this Section or one year whichever is less. New agreements shall be authorized only upon determination by the Department that the skilled nursing facility continues to meet the standards set forth in this Section."

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[12]Otherwise known as the Medicaid Act.

California Health and Safety Code § 1396.

"For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance."

California Welfare and Institutions Code § 14003.

"The Governor may enter into and execute in behalf of the state all necessary agreements in connection with this chapter as may be required by the United States government."

California Welfare and Institutions Code § 14020.

"All sections of this chapter shall remain in operation during such times as grants-in-aid are provided or made available to the state on the basis of a state plan approved by the federal government for medical assistance pursuant to provisions of the Federal Social Security Act, as amended."

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California Welfare and Institutions Code § 14100.1.

"For the purpose of administering this chapter, and Chapter 8 (commencing with Section 14500) of this part, the Secretary of the Health and Welfare Agency shall have those powers and duties necessary to conform to requirements for securing approval of a state plan under the provisions of the applicable federal law."

22 California Administrative Code § 50009.

"If the United States Department of Health, Education and Welfare issues a formal ruling that any section of this Subdivision relating to medical assistance cannot be given effect without causing this state's plan to be out of conformity with federal requirements, the section shall become inoperative to the extent that it is not in conformity with federal requirements."

45 C.F.R. § 249.33(a)(6).

"(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

". . .

"(6) Provide that execution of the single State agency provider agreement with a facility for payments under the plan shall be contingent upon certification in accordance with the provisions of paragraph (a)(1) and (2) of this section. The term of an agreement may not exceed a period of one year and the effective date of such agreement may not be earlier than the date of certification. Execution of a provider agreement shall be for the term and in accordance with the provisions of certification determined by the survey agency except that the single State agency for good cause based on adequate and documented evidence

may elect to execute a provider agreement for a term less than the full period of certification or may elect not to execute a provider agreement or may cancel a provided agreement for participation by a facility certified under the State plan. Notwithstanding the provisions of this subparagraph the single State agency may extend such term for a period not exceeding two months where the survey agency has notified the single State agency in writing prior to the expiration of a provider agreement that the health and safety of the patients will not be jeopardized thereby, and that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services or that it is impracticable within such provider agreement period to determine whether such facility is complying with the provisions and requirements under the program."

45 C.F.R. § 249.33(a)(4)(i).

"(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

". . .

"(4) Provide that certification by the survey agency designated pursuant to § 250.100(c) of this chapter will be subject to the following provisions and exclusions:

(i) For purposes of paragraph (a)(1)(i) of this section, the facility is in compliance with each condition of participation as determined by the manner and degree

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to which the facility satisfies the standards within each condition . . ."

45 C.F.R. § 249.10.

"(b) *Federal financial participation.* Subject to the limitations in paragraph (c) of this section, Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the following definitions:

". . .

"(4)(i) *Skilled nursing facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.* "Skilled nursing facility services" means services ordered by and under the direction of a physician provided in a skilled nursing facility (which term includes any institution located on an Indian reservation and certified by the Secretary as meeting the requirements of section 1861(j) of the Act), and which are or were:

". . .

"(C) Provided by a facility or distinct part of a facility which is certified to meet all of the requirements for participation pursuant to § 249.33 as evidenced by an agreement, executed in accordance with the certification provisions of § 249.33, between the single State agency and the facility for the provision of skilled nursing facility services and the making of payments under the plan . . ."

22 California Administrative Code § 51452.

"Violation of any rule or regulation relating to the provision of health care services under the California Medical Assistance Program by any individual, partnership, clinic, group, association, corporation, or institution, or any officer, director, agent, or employee, shall be deemed contrary to public health, safety, welfare, and morals, and to said program and grounds for suspension from the participation in said program."